State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Enclosed is the Medi-Cal provider enrollment application package you requested. Requests for additional application packages should be directed to Electronic Data Systems (EDS), the Medi-Cal fiscal intermediary, at (800) 541-5555.

PLEASE NOTE: Regulations effective February 2003 governing the enrollment of providers in the Medi-Cal program now require additional information to be submitted with the application package. Applications will be reviewed to ensure that applicants and providers meet the new criteria, including the verification of insurance.

Instructions for completion of these documents are included on the forms. Please read the instructions carefully. If after reading the instructions you have questions regarding the completion of the application, disclosure statement and/or provider agreement, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. to leave a message. Each applicant is sent written notice when the application package is received. Due to the volume of applications received, program staff is unable to reply to a request for the status of applications in process. Therefore, please allow for the 120 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Application packages that are incomplete or are submitted on a form other than the current Department of Health Services (DHS)-issued forms will be returned to you.

It is your responsibility to report to DHS any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Application* (DHS 6209). You may request a *Medi-Cal Supplemental Application* by contacting EDS.

For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the “Provider Enrollment” link.

If you have any questions, please the call Provider Enrollment Branch at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

MEDI-CAL PROVIDER APPLICATION

FOR STATE USE ONLY

Important:
- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply) | Date

- ❒ New provider
- ❒ Additional business address—Current Medi-Cal provider number: _____
- ❒ Add rendering provider to:
  - ❒ Provider group applicant—group name: _____
  - ❒ Existing provider group—specify group provider number: _____
- ❒ Delete as a rendering provider in a provider group—specify group provider number: _____
- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.) Current Medi-Cal provider number: _____

Type of entity

- ❒ Sole proprietor
- ❒ Partnership
- ❒ Government
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Limited liability corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement/Permit number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street) | City | County | State | Nine-digit ZIP code

5. "Pay to" address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

7. License number (attach legible copy) | License effective date | License expiration date | 8. Provider type | 9. Medicare billing number

10. Federal Employer Identification Number (FEIN)
(Attach a legible copy of the IRS form.)
____ ____ – ____ ____ ____ ____ ____ ____ ____

11. Social security number or Individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.) (See Privacy Statement on page 2.)
____ ____ ____ – ____ ____ – ____ ____ ____ ____

12. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)

13. State Laboratory License/Registration number (attach a legible copy)

14. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

15. Date of birth

16. Gender
❒ Male ❒ Female

Information About Individual Signing This Application

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17. Printed name of individual signing this application (last) (first) (middle)

18. Gender

❒ Male ❒ Female

19. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

20. Date of birth

21. Social security number (***Optional***—see Privacy Statement below.)

____ ____ ____ – ____ ____ – ____ ____ ____ ____

22. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

23. Notary Public—Please see instructions under number 23 for who must notarize.

Privacy Statement
(Civil Code, Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF MEDI-CAL PROVIDER APPLICATION

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment action requested (check all that apply); enter the date you are completing the application.

"New provider" means the applicant is not currently enrolled in the Medi-Cal program and would like to have a Medi-Cal provider number issued.

"Additional business address" means the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

"Add rendering provider" means to add a rendering provider to a provider group applicant or an existing provider group. If this is a request to be added as a rendering provider to a provider group applicant, enter the provider group name. If this is a request to be added as a rendering provider to an existing provider group, enter that provider group provider number.

"Delete as a rendering provider in a provider group" means you no longer wish to be enrolled as a rendering provider in a provider group. Specify the provider group number. If you are deleting from a provider group and wish to enroll in the Medi-Cal program as an individual provider, also check the "New provider" box and complete the entire application with information specific to your individual practice.

"Continued enrollment" means the provider is currently enrolled in the Medi-Cal program and would like to continue participation. Enter the provider number that you would like to continue to use. (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Regulations, Section 51000.55.)

"Type of Entity": Check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. "Legal name" means the name listed with the Internal Revenue Service (IRS).
2. "Business name" means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Ficitious Business Name Statement/Permit to the application.
3. "Business telephone number" means the primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. "Business address" means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. "Pay to address" means the address to which the applicant or provider wishes to receive payment. The "pay to" address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address" is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Provide the license/certificate number, or other approval to provide health care, of the applicant or provider. Attach a legible copy of the license, certification, or approval. Enter the effective date of the license/certificate number, or other approval. Enter the expiration date of the license/certificate, or other approval.
8. Enter the provider type (e.g., see list in Title 22, California Code of Regulations, Section 51051).
9. Insert the Medicare billing number.
10. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or form 2363.

11. If the business is a Sole Proprietorship not using a Federal Employer Identification Number (FEIN), provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN, if applicable.

12. Enter the Clinical Laboratory Improvement Amendment (CLIA) number. Attach a legible copy of the CLIA Certificate.

13. Provide the State Laboratory License/Registration number. If this does not apply to you, enter "N/A." Attach a legible copy of the license/registration.

14. Provide the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

15. List the date of birth of the individual named in number 1.

16. List the gender of the individual named in number 1.

17. "Printed name of the individual signing the application." Enter the last, first, and, middle name of an individual acting on behalf of and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.

18. Check (✓) the gender of the individual named in number 17.

19. Provide the driver's license or state-issued identification number and state of issuance of the individual named in number 17. Attach a legible copy to the application.

20. Enter the date of birth of the individual named in number 17.

21. Provide the social security number of the individual named in number 17. Provision of the social security number is optional (see Privacy Statement on page 2).

22. An original signature of the individual named in number 17 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

23. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, DO NOT have to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Driver's license or state-issued identification card
- ❒ FEIN or ITIN verification
- ❒ CLIA Certificate
- ❒ License, certification, or other approval
- ❒ Fictitious Business Name Statement/Permit
- ❒ State Laboratory License/Registration